

Department of Health & Human Services  
Centers for Medicare & Medicaid Services  
61 Forsyth St., Suite. 4T20  
Atlanta, Georgia 30303-8909



March 3, 2009

RECEIVED MAR 9 2009

Mr. Douglas Baker, Director  
Julian F. Keith Alcohol & Drug Abuse Treatment Center  
201 Tabernacle Road  
Black Mountain, NC 28711

Re: Psychiatric Hospital CMS Certification Number (CCN): **34-4023**

Dear Administrator:

Enclosed is the Statement of Deficiencies (CMS-2567) prepared by representatives of the Centers for Medicare & Medicaid Services following their survey of your facility on **January 12-14, 2009**. Please enter your plan of correction in the space provided on the right-hand inside of this form. Each deficiency must be addressed. Your plan of correction should reference the appropriate prefix tag.

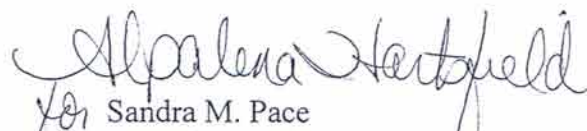
The plan of correction should state specifically how the deficiencies will be corrected, to include the time frame for completing the corrections. Statements such as "will be corrected", or "completed", will not be accepted. The completion date for each plan of correction should include the month, day, and year. If additional space is needed to complete the plan of correction, please attach a continuation page with the deficiencies clearly referenced. The facility's representative must sign and date the plan of correction.

You should retain a copy of the completed document for your records and return the original within 10 days to:

Sandra M. Pace, Associate Regional Administrator  
Division of Survey and Certification  
Centers for Medicare and Medicaid Services  
61 Forsyth Street, SW, Suite 4T20  
Atlanta, Georgia 30303-8909  
Attn: Alpalena Hartsfield

If you have any questions or concerns about this matter, please contact Alpalena Hartsfield at (404) 562-7434.

Sincerely,

  
for Sandra M. Pace  
Associate Regional Administrator  
Division of Survey and Certification

Enclosure (CMS-2567)

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 01/22/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>344023</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/14/2009</b>
NAME OF PROVIDER OR SUPPLIER <b>JULIAN F KEITH ALCOHOL &amp; DRUG ABUSE TREATI</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>301 TABERNACLE ROAD BLACK MOUNTAIN, NC 28711</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
B 000	INITIAL COMMENTS  An unannounced recertification survey was conducted by federal consulting surveyors from January 12-14, 2009. The census at the beginning of this survey was 73 patients; the sample of active patients was 8.	B 000			
B 108	482.61(a)(4) DEVELOPMENT OF ASSESSMENT/DIAGNOSTIC DATA  The social service records, including reports of interviews with patients, family members, and others, must provide an assessment of home plans and family attitudes, and community resource contacts as well as a social history.  This Standard is not met as evidenced by: Based on record review and interview, the facility failed to ensure that social service records included a summary of the social work data base with conclusions and recommendations for the social worker's anticipated role in treatment and discharge planning for 8 of 8 sample patients (A9, A19, A27, A36, B7, B15, C8 and C15).  This failure hindered treatment planning and discharge planning for the patient.  Findings are:  A. Patient A9 (psychosocial assessment of 12/31/08):  1. The social work summary failed to address issues noted in the data base: previous failed treatment, lack of financial resources, history of legal issues (Driving While Impaired) and family	B 108			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 01/22/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>344023</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/14/2009</b>
NAME OF PROVIDER OR SUPPLIER <b>JULIAN F KEITH ALCOHOL &amp; DRUG ABUSE TREATI</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>301 TABERNACLE ROAD BLACK MOUNTAIN, NC 28711</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
B 108	<p>Continued From page 1 problems.</p> <p>2. The psychosocial failed to include recommendations for the social work role in treatment.</p> <p>3. During interview on 1/13/09 at 11:45 AM, SW-A3 acknowledged the above findings.</p> <p>B. Patient A19 (psychosocial assessment undated):</p> <p>1. The social work summary failed to address issues noted in the data base: previous failed treatment, limited family support, homelessness, previous suicidality and sexual abuse..</p> <p>2. The psychosocial failed to include recommendations for the social work role in treatment.</p> <p>C. Patient A27:</p> <p>The psychosocial assessment (1/4/09) failed to include recommendations for the social work role in treatment.</p> <p>D. Patient A36:</p> <p>The psychosocial assessment (undated) failed to include recommendations for the social work role in treatment.</p> <p>E. Patient B7:</p> <p>The psychosocial assessment (1/1/09) failed to include recommendations for the social work role in treatment.</p> <p>F. Patient B15:</p>	B 108			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 01/22/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>344023</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/14/2009</b>
NAME OF PROVIDER OR SUPPLIER <b>JULIAN F KEITH ALCOHOL &amp; DRUG ABUSE TREATMENT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>301 TABERNACLE ROAD BLACK MOUNTAIN, NC 28711</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
B 108	Continued From page 2  The psychosocial assessment (1/5/09) failed to include recommendations for the social work role in treatment.  G. Patient C8:  The psychosocial assessment (1/9/09) failed to include recommendations for the social work role in treatment.  H. Patient C15:  The psychosocial assessment (12/25/08) failed to include recommendations for the social work role in treatment.	B 108			
B 109	482.61(a)(5) DEVELOPMENT OF ASSESSMENT/DIAGNOSTIC DATA  When indicated, a complete neurological examination must be recorded at the time of the admission physical examination.  This Standard is not met as evidenced by: Based on record review and interview, the neurological screening exams performed were inadequate for 6 of 8 sample patients (A9, A19, A27, B7, C8 and C15). This deficit resulted in important medical information being unavailable to the physician for accurate diagnosis.  Findings are:  A. Record Review  1. In 2 records (A27 dated 1/3/09, C8 dated 1/7/09) the only recorded information is	B 109			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 01/22/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>344023</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/14/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>JULIAN F KEITH ALCOHOL &amp; DRUG ABUSE TREATMENT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>301 TABERNACLE ROAD BLACK MOUNTAIN, NC 28711</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
B 109	<p>Continued From page 3</p> <p>cerebellar: a circle with a dash "Rhombberg," motor: "moving all 4 extremities," sensory: "reacts to light touch," a note under the cranial nerves section "grossly intact" and right and left reflexes noted as "1+" with lines extending down the columns below.</p> <p>2. In 2 records (A9 dated 12/30/08, A19 dated 12/31/08) the only recorded information is cerebellar: a circle with a dash "ROM, tremor," motor: "MAE," sensory: "intact," a note under the cranial nerves section "intact" and reflexes listed as "2."</p> <p>3. In 1 record (B7 dated 1/1/09) the only recorded information is cerebellar: a circle with a dash "Rhombberg," motor: "moving all 4 extremities," sensory: a down pointing arrow "sensation LE," a note under the cranial nerves section "grossly intact" and left and right reflexes noted as "1+" with lines extending down the columns below.</p> <p>4. In 1 record (C15 dated 12/23/08) the only recorded information is cerebellar: a circle with a dash "ROM," motor: "MAE," sensory: "intact," a note under the cranial nerves section "intact" and reflexes listed as "2."</p> <p>B. Staff Interview</p> <p>During an interview with the Medical Director on 1/13/09 at 10:00 am, the limited information recorded on the neurological section of the physical exam was discussed. He agreed that the information recorded lacked individual detail and did not provide a baseline for future comparisons.</p>	B 109			



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 01/22/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>344023</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/14/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>JULIAN F KEITH ALCOHOL &amp; DRUG ABUSE TREATMENT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>301 TABERNACLE ROAD BLACK MOUNTAIN, NC 28711</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
B 113	Continued From page 4	B 113			
B 113	<p>482.61(b)(3) PSYCHIATRIC EVALUATION</p> <p>Each patient must receive a psychiatric evaluation that must contain a record of mental status.</p> <p>This Standard is not met as evidenced by: Based on record review and interview, the facility failed to ensure that 6 of 8 sample patients (A9, A19, A36, B15, C8 and C15) received a psychiatric assessment containing a mental status examination that is descriptive, with documentation to support the patient's diagnosis and establish a baseline sufficient for comparison of treatment outcomes. The absence of detailed mental status evaluations makes objective patient assessment data unavailable to the treatment team and results in the staff being unable to accurately assess ongoing patient mental status and progress in treatment.</p> <p>Findings are:</p> <p>A. Record Review</p> <p>In 6 records (A9, A19, A36, B15, C8 and C15) the dictated/typed "Psychiatric Assessment" did not contain a mental status section. Some "Psychiatric Assessment Attachment" forms did have limited mental status information.</p> <p>B. Staff Interview</p> <p>During an interview with the Medical Director on 1/13/09 at 10:00 am, he stated that the dictated/typed "Psychiatric Assessments" should all contain complete mental status examinations in addition to any data documented in other</p>	B 113			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 01/22/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>344023</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/14/2009</b>
NAME OF PROVIDER OR SUPPLIER <b>JULIAN F KEITH ALCOHOL &amp; DRUG ABUSE TREATMENT</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>301 TABERNACLE ROAD BLACK MOUNTAIN, NC 28711</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
B 113	Continued From page 5 places in the record.	B 113		
B 121	<p>482.61(c)(1)(ii) TREATMENT PLAN</p> <p>The written plan must include short-term and long range goals.</p> <p>This Standard is not met as evidenced by: Based on record review and interview, the long-term treatment goals in the comprehensive plans for 7 of 8 sample patients (A9, A19, A36, B7, B15, C8 and C15) were stated in non-measurable terms and failed to identify the specific outcome behaviors for patients. In addition, some goals were not realistic for in-patient treatment. Goals on the comprehensive treatment plans were selected from a computerized program without patient individualization.</p> <p>This failure hinders the treatment team's ability to measure change in the patient consequent to treatment interventions.</p> <p>Findings are:</p> <p>A. Record Review</p> <p>1. Patient A9 (plan dated 1/6/09):</p> <p>a. For the problem, "symptoms of depression," the goal is stated as "Patient will experience a reduction in his symptoms of depression."</p> <p>This goal failed to specific the behaviors reflected a reduction in depression.</p> <p>b. For the problem, "inability to maintain sobriety,</p>	B 121		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 01/22/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>344023</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/14/2009</b>
NAME OF PROVIDER OR SUPPLIER <b>JULIAN F KEITH ALCOHOL &amp; DRUG ABUSE TREAT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>301 TABERNACLE ROAD BLACK MOUNTAIN, NC 28711</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
B 121	<p>Continued From page 6</p> <p>despite previous attempts at treatment," the goal is stated as "Will maintain sobriety upon discharge from hospital."</p> <p>This goal is not realistic; goals after discharge are not measurable during hospitalization.</p> <p>2. Patient A19 (plan dated 15/09):</p> <p>a. For problem, "symptoms of depression," the goal was stated as "Patient will experience a reduction in his symptoms of depression."</p> <p>This goal is not measurable.</p> <p>b. For problem, "symptoms of anxiety," the goal was stated as "Will demonstrate a decrease in symptoms of anxiety..."</p> <p>This goal is not measurable.</p> <p>c. For the problem, "inability to maintain sobriety, despite previous attempts at treatment," the goal is stated as "Will maintain sobriety upon discharge from hospital."</p> <p>This goal is not realistic; goals after discharge are not measurable during hospitalization.</p> <p>3. Patient A36 (plan dated 1/8/09):</p> <p>a. For problem, "symptoms of anxiety," the goal was stated as "Will demonstrate a decrease in symptoms of anxiety..."</p> <p>b. For problem, "Needs understanding of medications prescribed as well as general medication information," the goal was stated as "Will have knowledge of own medication uses and side effects and will learn about general</p>	B 121			



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 01/22/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>344023</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/14/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>JULIAN F KEITH ALCOHOL &amp; DRUG ABUSE TREATMENT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>301 TABERNACLE ROAD BLACK MOUNTAIN, NC 28711</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
B 121	<p>Continued From page 7 medications."</p> <p>The above goals were not measurable.</p> <p>c. For the problem, "inability to maintain sobriety, despite previous attempts at treatment," the goal is stated as "Will maintain sobriety upon discharge from hospital."</p> <p>This goal is not realist; goals after discharge are not measurable during hospitalization.</p> <p>d. For the problem, "inability to maintain sobriety, despite previous attempts at treatment," the goal is stated as "Will maintain sobriety upon discharge from hospital."</p> <p>This goal is not realistic; goals after discharge are not measurable during hospitalization.</p> <p>4. Patient B7 (plan dated 1/6/09):</p> <p>a. For problem, "Difficulty dealing effectively with anger," the goal was listed as "Will recognize and understand the effects of mismanaged/unresolved anger and resentment and the barriers they pose to recovery."</p> <p>This goal was not measurable.</p> <p>b. For the problem, "Demonstrates and/or has a history of a mood disorder involving symptoms of mania and depression," the goal was stated as "...will evidence a reduction in symptomology (sic) conducive to out patient treatment."</p> <p>This goal was not measurable.</p> <p>c. For the problem, "inability to maintain sobriety, despite previous attempts at treatment," the goal</p>	B 121			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 01/22/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>344023</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/14/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>JULIAN F KEITH ALCOHOL &amp; DRUG ABUSE TREATMENT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>301 TABERNACLE ROAD BLACK MOUNTAIN, NC 28711</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
B 121	<p>Continued From page 8</p> <p>is stated as "Will maintain sobriety upon discharge from hospital."</p> <p>This goal is not realistic; goals after discharge are not measurable during hospitalization.</p> <p>5. Patient B15 (plan dated 1/5/09):</p> <p>a. For the problem, "Lacks appropriate information about the dynamics of addiction," the goal was stated as "Will increase her knowledge of the dynamics of chemical dependency and addiction as it relates to her recovery."</p> <p>This goal was not measurable.</p> <p>6. Patient C8 (initial plan dated 1/7/09):</p> <p>For problem, "Relapse Prevention," the goal was stated as "Will maintain sobriety upon discharge for hospital."</p> <p>This goal is not realistic; goals after discharge are not measurable during hospitalization.</p> <p>7. Patient C15 (initial plan dated 12/24/08):</p> <p>For problem, "Disturbance in perceptual field and disruption of thought processes as evidenced by Auditory Hallucinations," the goal was stated as A.V. [Auditory Visual] hallucinations will be minimized."</p> <p>This goal is not measurable.</p> <p>B. Staff Interview:</p> <p>During interview, with record review, on 1/14/09 at 11:30 AM, the Clinical Director acknowledged that goals were not stated in measurable terms.</p>	B 121			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 01/22/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>344023</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/14/2009</b>
NAME OF PROVIDER OR SUPPLIER <b>JULIAN F KEITH ALCOHOL &amp; DRUG ABUSE TREATMENT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>301 TABERNACLE ROAD BLACK MOUNTAIN, NC 28711</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
B 121	Continued From page 9	B 121			
B 122	<p>482.61(c)(1)(iii) TREATMENT PLAN</p> <p>The written plan must include the specific treatment modalities utilized.</p> <p>This Standard is not met as evidenced by: Based on interview and record review, the facility failed to adequately develop and document individualized treatment interventions based on the needs of 8 of 8 sample patients (A9, A19, A27, A36, B7, B15, C8 and C15). Some of the interventions were expected staff functions, rather than individualized patient interventions. In addition, there was failure to document treatment interventions in the comprehensive treatment plans to address medical physical/ problems.</p> <p>This deficiency resulted in a failure to provide a basis for accurate implementation of treatment based on individual patient findings.</p> <p>Findings are:</p> <p>A. Patient A9 (plan dated 1/6/09):</p> <p>1. For problem, "symptoms of depression," the intervention was stated as "[Physician] will evaluate the need for medications and prescribe as appropriate." "[Nurse] or designee will administer medications as prescribed by [name deleted] and document the effectiveness and any side effects." "[Nurse] will provide (patient) with medication education specific to the medication(s) he is receiving."</p> <p>This intervention consisted of expected role functions and was not individualized based on</p>	B 122			



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 01/22/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>344023</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/14/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>JULIAN F KEITH ALCOHOL &amp; DRUG ABUSE TREATMENT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>301 TABERNACLE ROAD BLACK MOUNTAIN, NC 28711</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
B 122	<p>Continued From page 10 patient findings.</p> <p>2. As documented in the psychiatric assessment (12/31/08) Patient A9 had attempted suicide about 1 month before admission by drinking a gallon of antifreeze, presents with a history significant for depression and diagnosed with Major Depressive Disorder, Recurrent. There were no interventions, including those to ensure safety in the clinical area, to address his potential for suicide.</p> <p>During interview on 1/13/09 at 1:00 PM with Physicians A1 and A2, Physician A1 acknowledged that the treatment plan for Patient A27 failed to adequately address his potential for suicide.</p> <p>3. Under treatment plan section, "Biomedical Conditions and complications Problems," for Problem #5 (unnamed) the following statement is documented, "Problems will be resolved and progress charted in the progress notes by the time of discharge, or (patient) will be referred to local medical doctor for continuing medical treatment."</p> <p>The comprehensive treatment plan failed to include the interventions to guide personnel in the patient's treatment.</p> <p>B. Patient A19 (plan dated 1/5/09):</p> <p>Under treatment plan section, "Biomedical Conditions and complications Problems," for Problem #5 (unnamed) the following statement is documented, "Problems will be resolved and progress charted in the progress notes by the time of discharge, or (patient) will be referred to local medical doctor for continuing medical</p>	B 122			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 01/22/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>344023</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/14/2009</b>
NAME OF PROVIDER OR SUPPLIER <b>JULIAN F KEITH ALCOHOL &amp; DRUG ABUSE TREATI</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>301 TABERNACLE ROAD BLACK MOUNTAIN, NC 28711</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
B 122	<p>Continued From page 11 treatment."</p> <p>The comprehensive treatment plan failed to include the interventions to guide personnel in the patient's treatment.</p> <p>C. Patient A27 (no master treatment plan):</p> <p>1. As of noon on 1/13/09 the comprehensive treatment plan for Patient A27 was not present in the medical record. Although Patient A27 admitted on 1/2/09 and a treatment team meeting (documented in treatment team notes (1/12/09) was conducted,</p> <p>During interview on 1/13/09 at 1:00 PM with Physicians A1 and A2, Physician A1 reported that Patient A27 comprehensive treatment plan should have been filed in his medical record.</p> <p>2. In the initial treatment plan (dated 1/2/09) for Patient A27, for the problem, "SI's plan (suicidal ideation without plan)," the only documented interventions are:</p> <p>a. "Nursing staff will provide a safe environment and will monitor (patient) every 15-30 minutes as ordered and prn."</p> <p>This is an expected function of nursing; all patients are monitored every 15-30 minutes.</p> <p>b. "The medical staff will assess (patient) for changes in mood, mental status, and behavior. The nursing staff will assess (patient) every shift and prn for the above and report significant information to the medical staff."</p> <p>c. "The nursing staff will administer medication as ordered. The Medical staff and Nursing staff will evaluate effectiveness of medication."</p>	B 122			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 01/22/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>344023</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/14/2009</b>
NAME OF PROVIDER OR SUPPLIER <b>JULIAN F KEITH ALCOHOL &amp; DRUG ABUSE TREATMENT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>301 TABERNACLE ROAD BLACK MOUNTAIN, NC 28711</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
B 122	<p>Continued From page 12</p> <p>These above documented interventions are expected patient assessments and role functions, rather than interventions based on significant patient findings.</p> <p>D. Patient A36 (plan dated 1/8/09):</p> <p>1. For the problem, "Needs understanding of medications prescribed as well as general medication information," the intervention was stated as "Nursing will present education classes on general medications."</p> <p>This intervention failed to include the specific focus of the education based on the patient findings.</p> <p>2. Under treatment plan section, "Biomedical Conditions and complications Problems," for Problem #5 (unnamed) the following statement is documented, "Problems will be resolved and progress charted in the progress notes by the time of discharge, or (patient) will be referred to local medical doctor for continuing medical treatment."</p> <p>The comprehensive treatment plan failed to include the interventions to guide personnel in the patient's treatment.</p> <p>E. Patient B7 (plan dated 1/6/09):</p> <p>Under treatment plan section, "Biomedical Conditions and complications Problems," for Problem #5 (unnamed) the following statement is documented, "Problems will be resolved and progress charted in the progress notes by the time of discharge, or (patient) will be referred to local medical doctor for continuing medical</p>	B 122			



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 01/22/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>344023</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/14/2009</b>
NAME OF PROVIDER OR SUPPLIER <b>JULIAN F KEITH ALCOHOL &amp; DRUG ABUSE TREATMENT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>301 TABERNACLE ROAD BLACK MOUNTAIN, NC 28711</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
B 122	<p>Continued From page 13 treatment."</p> <p>The comprehensive treatment plan failed to include the interventions to guide personnel in the patient's treatment.</p> <p>F. Patient B15 (plan dated 1/5/09):</p> <p>1. For the problem, "Experiencing symptoms of low or damaged self-esteem...", there was failure to identify nursing interventions to assist the patient in the clinical area to address this issue.</p> <p>2. For the problem, "Lacks appropriate information about the dynamics of addiction," the intervention was stated as "Staff nurses or designee will assist (patient) in recording significant information and will document progress."</p> <p>This intervention failed to include the specific types of information to be addressed based on specific patient findings.</p> <p>3. Under treatment plan section, "Biomedical Conditions and complications Problems," for Problem #5 (unnamed) the following statement is documented, "Problems will be resolved and progress charted in the progress notes by the time of discharge, or (patient) will be referred to local medical doctor for continuing medical treatment."</p> <p>The comprehensive treatment plan failed to identify interventions to guide personnel in the patient's treatment.</p> <p>G. Patient C8 (initial plan dated 1/7/09):</p> <p>1. For the problem, "Mild sedative withdrawal, not</p>	B 122			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 01/22/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>344023</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/14/2009</b>
NAME OF PROVIDER OR SUPPLIER <b>JULIAN F KEITH ALCOHOL &amp; DRUG ABUSE TREATMENT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>301 TABERNACLE ROAD BLACK MOUNTAIN, NC 28711</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
B 122	<p>Continued From page 14</p> <p>requiring medications for detoxification," an intervention was stated as "Medical staff will assess the possibility of (patient) needing detoxification with medications on a daily basis, and prescribe proper medication for sedative withdrawal if (patient's) clinical condition changes."</p> <p>This intervention is a statement of expected staff role functions.</p> <p>H. Patient C15 (initial plan dated 12/24/08):</p> <p>For problem, "Disturbance in perceptual field and disruption of thought processes as evidenced by Auditory Hallucinations," the interventions were documented as "Medical Staff to prescribe anti-psychotic medications and educate patient on same. Nursing staff to administer anti-psychotic meds [medications] and evaluate efficacy. Nursing staff to reinforce medication education given by medical staff."</p> <p>These interventions are statements of expected staff role functions. There were no nursing interventions to address the care of this patient in the clinical area based on patient findings.</p>	B 122			
B 135	<p>482.61(e) DISCHARGE PLANNING</p> <p>The record of each patient who has been discharged must have a brief summary of the patient's condition on discharge.</p> <p>This Standard is not met as evidenced by: Based on record review and interview, the facility failed to ensure that the discharge summaries for 5 of 7 discharged patients (D2, D3, D5, D6 and</p>	B 135			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 01/22/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>344023</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/14/2009</b>
NAME OF PROVIDER OR SUPPLIER <b>JULIAN F KEITH ALCOHOL &amp; DRUG ABUSE TREATMENT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>301 TABERNACLE ROAD BLACK MOUNTAIN, NC 28711</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
B 135	<p>Continued From page 15</p> <p>D7) contained a summary of the patient's condition on discharge. This results in the subsequent provider lacking valuable information that could facilitate interventions, in a timely manner, to prevent relapse.</p> <p>Findings are:</p> <p>A. Record Review</p> <p>1. In 2 patients (D2 and D5) the Condition at Discharge was: "The patient was biomedically stable and clinically improved."</p> <p>2. In 1 patient (D3) the Condition at Discharge was: "Discharged psychiatrically and medically stable."</p> <p>3. In 1 patient (D6) the Condition at Discharge was: "The patient was biomedically stable and clinically unchanged."</p> <p>4. Patient D7 attempted suicide during his hospitalization. As documented in a nursing progress note (11/6/08), Patient D7 was "found in [sic] bathroom floor with sheet wrapped around neck about 6 times."</p> <p>Even though this event occurred during this patient's hospitalization, his discharge summary (12/12/08) failed to address this event. The only statement stated under the "Condition At Discharge" section was stated as "Discharged in a stable physical and emotional health."</p> <p>B. Staff Interview</p> <p>In interview on 1/12/09 at 4:15 PM, the Medical Director agreed that the Conditions at Discharge were general statements and were not</p>	B 135			



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 01/22/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>344023</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/14/2009</b>
NAME OF PROVIDER OR SUPPLIER <b>JULIAN F KEITH ALCOHOL &amp; DRUG ABUSE TREATMENT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>301 TABERNACLE ROAD BLACK MOUNTAIN, NC 28711</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
B 135	Continued From page 16 individualized.	B 135			
B 144	<p>482.62(b)(2) MEDICAL STAFF</p> <p>The director must monitor and evaluate the quality and appropriateness of services and treatment provided by the medical staff.</p> <p>This Standard is not met as evidenced by: Based on record review and interview, the Medical Director failed to ensure quality control of the psychiatric assessments and the physical examinations conducted.</p> <p>Specifically there was failure to:</p> <p>I. Ensure the adequacy of the neurological screening examination performed in 6 of 8 sample records reviewed (A9, A19, A27, B7, C8 and C15). This deficit resulted in important medical information being unavailable to the physician for accurate diagnosis. (Refer to B109.)</p> <p>II. Ensure that psychiatric assessments included a documented mental status examination in 6 of 8 sample records reviewed (A9, A19, A36, B15, C8 and C15). This failure to document the baseline mental status impairs the ability of the treatment staff to accurately assess progress in treatment. (Refer to B113.)</p> <p>III. Ensure that comprehensive plans included patient-related long-term treatment goals stated in measurable, behavioral terms for 7 of 8 sample patients (A9, A19, A36, B7, B15, C8 and C15). This failure hinders the ability of the treatment team to measure change in the patient as a result of the treatment interventions. (Refer to B121.)</p>	B 144			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 01/22/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>344023</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/14/2009</b>
NAME OF PROVIDER OR SUPPLIER <b>JULIAN F KEITH ALCOHOL &amp; DRUG ABUSE TREATMENT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>301 TABERNACLE ROAD BLACK MOUNTAIN, NC 28711</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
B 144	Continued From page 17  IV. Ensure that treatment plans were developed that included individualized treatment interventions to address specific patient problems for 8 of 8 sample patients (A9, A19, A27, A36, B7, B15, C8 and C15). This failure results in a lack of guidance for staff in providing individualized patient treatment. (Refer to B122).  V. Ensure that discharge summaries contained a summary of the patient's condition on discharge for 5 of 7 discharge records reviewed (D2, D3, D5, D6 and D7). This failure results in the subsequent provider lacking valuable information to assist in future treatment. (Refer to B135.)	B 144			
B 148	482.62(d)(1) NURSING SERVICES  The director must demonstrate competence to participate in interdisciplinary formulation of individual treatment plans; to give skilled nursing care and therapy; and to direct, monitor, and evaluate the nursing care furnished.  This Standard is not met as evidenced by: Based on record review and interview, the Director of Nursing failed to ensure that specific interventions were documented in the treatment plans of 8 of 8 sample patients (A9, A19, A27, A36, B7, B15, C8 and C15). The majority of nursing interventions were chosen from preprinted forms or computerized plans without specifics based on patient findings.  This resulted in the absence of interventions to guide nursing personnel in the implementation and evaluation of patient care. (Refer to B122.)	B 148			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 01/22/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>344023</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/14/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>JULIAN F KEITH ALCOHOL &amp; DRUG ABUSE TREATMENT</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>301 TABERNACLE ROAD BLACK MOUNTAIN, NC 28711</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
B 148	Continued From page 18 During interview with the Director of Nursing on 1/13/09 at 4:00 PM, she acknowledged that nursing interventions in the treatment plans were inadequate, with the majority being statement of expected role functions.	B 148			